# CHAMPVA POLICY MANUAL

**CHAPTER: 3**
**SECTION: 5.2**
**TITLE: CLAIMCHECK®**

**AUTHORITY:** 38 USC 1713; 38 CFR 17.270(a) and 38 CFR 17.272(b)

**RELATED AUTHORITY:** 32 CFR 199.4

**TRICARE POLICY MANUAL:** Chapter 11, Section 14.1. and Chapter 13, Section 1.5

## I. EFFECTIVE DATE

January 15, 1996

## II. DESCRIPTION

ClaimCheck® is a fully automated cost containment program that is designed to ensure appropriate coding on professional claims. Edits do not apply to inpatient institutional claims except for ambulatory surgery facility claims. ClaimCheck® is a reviewed, approved and customized version of HBO & Company (formerly GMIS) ClaimCheck®. Edits are developed through a Clinical Information Services Department, with input from the Clinical Consulting Network. This includes yearly CPT updates, and incorporation of Medicare guidelines as well as Specialty Society guidelines.

## III. POLICY

A. ClaimCheck® will be applied to claims based on the date of service. The appropriate reimbursement methodology will be applied in conjunction with ClaimCheck® auditing guidelines.

B. Edits. The following edits are considered when auditing claims:

1. Integral: A procedure that is carried out at the same time as a larger more complex primary procedure. It requires little additional physician resources and/or is an integral part of the primary procedure; thus it will not be reimbursed separately on a claim.

2. Mutually exclusive: The separate billing for two or more procedures that are usually not performed during the same patient encounter on the same date of service. Under ClaimCheck®, only the most clinically intensive procedure is allowed.

3. Assistant surgeon: When a procedure is submitted with an assistant surgeon modifier (-80, -81, or -82), ClaimCheck® determines whether that procedure always, sometimes, or never requires an assistant surgeon. If the determination is always, the modified code will pay, if the determination is never, the modified code will be rejected, if the determination is sometimes, medical review of the procedure will be necessary.

4. Duplicate: ClaimCheck® uses duplicate checking to identify procedures which appear two or more times on a claim that can only be performed once on a single date of service. Duplicate procedures will be rejected if one of these conditions exist.

5. Visits: Evaluation and management services that should be included with the surgery are denied.

6. Age conflict: Identifies procedures that are inappropriate for a patient's age. Claims, which indicate an age conflict, will be reviewed for the appropriateness of the code.

7. Sex conflict: Identifies procedures that are inappropriate for a patient's sex. Claims, which indicate a sex conflict, will be reviewed for the appropriateness of the code.

8. Cosmetic procedures: Identifies procedures that are usually performed for cosmetic reasons. Claims with cosmetic procedures will be reviewed for medical necessity.

9. Unlisted procedures: Identifies CPT codes that are used for procedures that do not have a specific code assignment. Claims with unlisted procedures will be reviewed.

10. Obsolete procedures: Identifies CPT codes that are no longer performed under prevailing medical standards. Claims with obsolete procedures will be reviewed.

## IV. POLICY CONSIDERATIONS

A. Appeals of ClaimCheck® edits will be handled on a case-by-case basis. Provider should submit medical documentation to request additional payment of procedure(s) denied by ClaimCheck®.

B. The following procedures, which may have been separately reimbursed in the past, are no longer eligible for separate CHAMPVA cost sharing. Payment for these services are now included in the payment for other services.

| CPT CODES | SERVICE DESCRIPTION |
|---|---|
| 15850 | Remove sutures under anes., same surgeon |
| 20930 | Allograft, morselized |
| 20936 | Autograft, same incision |
| 22841 | Internal spinal fixation |
| 78890 | Generation of automated data <=30 min. |
| 78891 | Generation of automated data >=30 min. |
| 90825 | Psych. Eval of records, reports, tests |
| 92340-92342 | Fitting of spectacles, eyeglasses |
| 92352-92358 | Special services for aphakia |
| 92370-92371 | Repair and refit spectacles |
| 92531-92534 | Vestibular function tests |
| 94150 | Vital Capacity, Total (Separate Procedure) |
| 97010 | Hot or cold packs |
| 99024 | Post-op follow-up visit included in global service |
| 99025 | Initial patient visit when minor surg. Done |
| 99050 | Visit after normal office hours |
| 99052 | Visit 10pm-8am |
| 99054 | Visit on Sunday/holiday |
| 99056 | Visit outside office due to patient request |
| 99058 | Office services on emergency basis |
| 99288 | Physician direction of EMS/ALS |
| 99358, 99359 | Prolonged E&M services before/after visit |

## V. EXCLUSIONS

The following claims are not subject to ClaimCheck:

1. Pharmacy.

2. Dental.

3. Durable medical equipment (DME).

4. Inpatient institutional claims.

***END OF POLICY***